STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155109	A. BUILDING _____ B. WING _____	R-C 07/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-MISHAWAKA	811 E 12TH ST MISHAWAKA, IN 46544

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This survey was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00173996 completed on June 3, 2015.

This visit was in conjunction with the Investigation of Complaint IN00175759.

Complaint IN00173996 - Corrected

Survey dates: July 7 and 8, 2015

Facility number: 000045
Provider number: 155109
AIM number: 100291400

Census bed type:
SNF/NF: 65
Total: 65

Census by payor type:
Medicare: 6
Medicaid: 53
Other:6
Total: 65

Golden Living Center - Mishawaka was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00173996.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE